DEPARTMENT FOR MEDICAID SERVICES
DIRECT DEPOSIT AUTHORIZATION FORM

The purpose of this form is to comply with Phase III CORE 380 EFT Enrollment Data Rule Version 3.00 June 2012.

Provider Information:

Provider Name: _____

Provider Identifiers:

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):
_____

National Provider Identifier (NPI): _____

KY Medicaid Provider Number (Assigning Authority): _____

Provider Contact Information:

Provider Contact Name: _____
Title: _____
Telephone Number: _____
Email Address: _____

Financial Institution Information:

Financial Institution Name: _____

Financial Institution Routing Number: _____

Type of Account at Financial Institution (select one): ☐ Checking ☐ Savings

Provider's Account Number with Financial Institution: _____

Note: Account Number Linkage to Provider Identifier- Provider preference for grouping (bulking) claim payments-must match preference for v5010 X 12 835 remittance advice.

Submission Information:

Reason for Submission:

☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

Include with Enrollment Submission:

☐ Voided Check ☐ Bank Letter

CLEAR FORM

I, the undersigned, authorize the Department for Medicaid Services to initiate accounting transactions to deposit payments directly to the account indicated above. These deposits will pertain only to direct deposit payments for Medicaid services that the payee has rendered.

I understand that in the event that my account information should change, I must notify the Kentucky Medicaid agency immediately. I will not hold the Kentucky Medicaid agency liable for presentation of any or all direct deposits into the account indicated above if I fail to notify Kentucky Medicaid or the fiscal agent of my change in bank account information.

If "Cancel Enrollment" is indicated under "Reason for Submission", I, the undersigned, hereby cancel the authorization for the Department for Medicaid Services to originate direct deposit entries into my checking/savings account.

I further acknowledge that I must contact my financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Reassociation Data Elements needed for reassociation of the payment.

I understand in endorsing or depositing this check (EFT) that payment will be from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.

Authorized Signature _____Date: _____

Title _____

INSTRUCTIONS FOR DIRECT DEPOSIT AUTHORIZATION FORM

FIELD NAME	FIELD INSTRUCTION
Provider Name	Complete legal name of institution, corporate entity, practice or individual provider .
Provider Federal Tax Identification Employer Identification Number	A Federal Tax Identification Number, also known as an Employer Identification Number (EIN) is used to identify a business entity
NPI (National Provider Identifier)	A Health Insurance Portability and Accountability Act (HIPPA)…
KY Medicaid Provider Number/ Assigning Authority	Organization that issues and assigns the additional identifier requested on the form.
Provider Contact Name	Name of contact in provider's office handling EFT issues.
Title	Title of provider contact
Telephone Number	Telephone number associated with contact person
Email Address	An electronic mail address at which DMS might contact the provider
Financial Institution Name	Official name of the provider's financial institution
Financial Institution Routing Number	A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited.
Type of Account at Financial Institution	The type of account the provider will use to receive EFT payments, e.g., Checking, Saving
Provider's Account Number with Financial Institution	Provider's account number at the financial institution to which EFT payments are to be deposited
New Enrollment/Change Enrollment/Cancel Enrollment	Indicate by marking the appropriate box for the purpose of submission
Include with Enrollment Submission	Voided Check- A voided check is attached to provide confirmation of Identification/Account Numbers or Bank Letter- A letter on bank letterhead that formally certifies that account owners' routing and account numbers.
Authorized Signature	The signature of an individual authorized by the provider or it's agent to initiate, modify, or terminate an enrollment. For individual providers, the individual must sign.

Note: For late/missing EFT resolution, please contact HP Provider Inquiry at 1-800-807-1232.

SUBMIT COMPLETED FORM TO:
KY Medicaid
P.O. Box 2110
Frankfort, KY 40602-2110
FOR QUESTIONS REGARDING THIS FORM:
Telephone: 877-838-5085
Email Address: Program.Integrity@ky.gov